MDR Tracking Number: M5-04-1608-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on February 4, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The myofascial release, hot/cold pack therapy, electrical stimulation-unattended, ultrasound, therapeutic exercises, and office visits from 02-04-03 through 05-16-03 **were found** to be medically necessary. The myofascial release, hot/cold pack therapy, electrical stimulation-unattended, ultrasound, therapeutic exercises, office visits, diathermy, manual therapeutic technique, electrical stimulation, required reports and therapeutic activities from 05-20-03 through 11-11-03 **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

This Findings and Decision is hereby issued this 16th day of September 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order. This Order is applicable to dates of service 02-04-03 through 05-16-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 16th day of September 2004.
Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division
RL/pr

NOTICE OF INDEPENDENT REVIEW DECISION

September 13, 2004

Re: IRO Case # M5-04-1608
IRO Certificate #4599

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Orthopedic Surgery, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of disputed service
2. Explanation of benefits
3. D.C. medical dispute letter 2/3/04
4. Orthopedic surgeon letters 3/2/04, 2/21/03
5. Patient letter 2/25/04
6. Orthopedic surgeon reports
7. Report MRI of left knee 12/13/02, 6/7/02
8. Report bone scan 10/28/02
9. Report M.D. outpatient consultation 7/18/02
10. Radiographic report left knee 5/15/02

11. D.C. initial report 5/3/02
12. Operative report 2/19/03
13. D.C. reports and progress notes

History

The patient had a traumatic injury to her left knee in ___. She sought chiropractic treatment, and was referred to an orthopedic surgeon in July 2002. an MRI demonstrated a meniscal tear and arthroscopy was recommended. The treating physician then sent the patient to another orthopedic surgeon who wanted to delay surgery for the acute meniscal tear and sent the patient back to therapy. The patient received therapy until arthroscopy was performed in February 2003. The treating physician and orthopedic surgeon determined that the patient had a component of dystrophy and myofascial pain that needed to be treated and stabilized prior to entertaining surgical management. Post operatively, the patient was sent back to physical therapy for an extended period of time.

Requested Service(s)

Myofas rel, hot-cold pack ther, elec stim unattended, ultrasound, ther exr, OV, req report, diathermy, man ther, elec stim ther activity 2/4/03 – 11/11/03

Decision

I disagree with the carrier's decision to deny the requested services through 5/19/03.
I agree with the decision to deny the requested services after 5/19/03.

Rationale

According to the records provided for this review, the patient had hyper-exaggerated pain syndrome with an associated meniscal tear and knee synovitis. Therefore, prior to surgery until approximately three months after surgery therapy was reasonable and necessary. However, after that point, physical therapy would not be appropriate without a corroborating diagnosis from a second opinion or appropriate diagnostic testing by a pain management specialist or a physical medicine and rehabilitation specialist. Without further consultation, physical therapy should not continue when the patient continues to have symptoms three months after arthroscopy. A diagnosis of dystrophy or CRPS was not adequately documented, and was inadequate to support the physical therapy beyond three months post-op.